BIRMINGHAM CITY COUNCIL

JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE (BIRMINGHAM AND SOLIHULL)

THURSDAY, 02 DECEMBER 2021 AT 14:00 HOURS
IN BMI MAIN HALL, 9 MARGARET STREET, BIRMINGHAM, B3 3BS

A G E N D A

1 **NOTICE OF RECORDING/WEBCAST**

The Chair to advise/meeting to note that this meeting will be webcast for live or subsequent broadcast via the Council's meeting You Tube site (www.youtube.com/channel/UCT2kT7ZRPFCXq6_5dnVnYlw) and that members of the press/public may record and take photographs except where there are confidential or exempt items.

2 **APOLOGIES**

To receive any apologies.

3 **DECLARATIONS OF INTERESTS**

Members are reminded that they must declare all relevant pecuniary and non pecuniary interests arising from any business to be discussed at this meeting. If a disclosable pecuniary interest is declared a Member must not speak or take part in that agenda item. Any declarations will be recorded in the minutes of the meeting.

4 **MINUTES** **3 - 12**

To note the minutes of the last meeting held on 29th September 2021.

5 **MID-YEAR REPORT ON THE STAFF ENHANCED WELLBEING OFFER** **13 - 22**

Lisa Stalley-Green, Chief Nurse, University Hospital Birmingham, Vice Chair People Board.

(1405-1435hrs)

23 - 36

6 **H2 PLANNING AND THE DEVELOPMENT OF A MULTI-YEAR RECOVERY PLAN**

Paul Athey, Chief Finance Officer, Birmingham and Solihull Clinical Commissioning Group.

(1435-1520hrs)

7 **ICS UPDATE AND THE ROLE OF SCRUTINY**

David Melbourne, Birmingham and Solihull ICS, Interim Designate Chief Executive

(1520-1600hrs)

8 **DATE OF THE NEXT MEETING**

The next meeting is scheduled to take place on Thursday 10th March 2022 at 1600 hours in the Civic Suite, Solihull.

JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE - 29 September 2021

MINUTES

Present: Councillors: A Hodgson, D Howell, M McCarthy, D Pinwell, R Sexton, Fowler and Pocock

Invited Solihull Council Councillors:
Councillors: M Brain and R Long

Officers: Solihull Council:
Joe Suffield – Democratic Services Officer

Birmingham City Council:
Gail Sadler – Scrutiny Officer
Ceri Saunders – Overview and Scrutiny Manager

External Guests: Birmingham and Solihull Clinical Commissioning Group
Paul Athey – Chief Financial Officer
Paul Sherriff – Chief Officer for Primary Care and Integration
Jennifer Weigham - Acting Head of Communications and Engagement

Solihealth
Dr Sunaina Khanna – Clinical Director of GPS Healthcare
Dr Dan Reid – Clinical Director of Solihull Rural Primary Care Network (PCN)
Dr Anand Chitnis – Clinical Director of North Solihull PCN

Long COVID Support
Claire Hastie - Founder

1. APOLOGIES

Apologies were received from Councillor Brown, Idrees and Tilsley.

2. DECLARATION OF INTERESTS

There were no declarations of interests.

3. QUESTIONS AND DEPUTATIONS

There were no questions or deputations received.

4. MINUTES

The minutes of the informal meeting held on 10th June 2021 were presented for information.

5. ACCESS TO PRIMARY CARE

The Chief Officer for Primary Care and Integration introduced the item, and highlighted the following points:

- General Practice activity was at June 2019 levels, and had exceeded pre-COVID-19 levels. This did not include the work undertaken for the vaccination programme. The way this care was delivered had changed, as a result of workforce levels and the required safety measures. Face-to-face appointments continued to increase locally, but were balanced with virtual appointments. Around 55% of patients now received face-to-face appointments, compared with 80% pre-COVID-19.
- Due to the increase in demand for GP services, Birmingham and Solihull Clinical Commissioning Group (BSol CCG) had worked to create surge capacity. This included extra clinics across Birmingham and Solihull, as well as red sites specifically for patients with COVID-19 symptoms.
- It was recognised that there were increased concerns from residents about access to Primary Care, which was a result of the heightened demand for the service. There was also a lot of verbal abuse and aggressive behaviour to reception staff. This had resulted in a number of resignations from clinicians and support staff.
- During autumn and winter, it was intended to retain the additional COVID-19 red sites. This was because demand would continue for these services, as COVID-19 symptoms increased.
- Alongside urgent GP appointments, there remained in place appointments for patients with long term conditions, annual health checks, immunisations and screening programmes. This highlighted the range of activity which would take place in GPs, as well as the COVID-19 vaccination activity.
- It was highlighted that there were significant attempts to improve services, however there would not be a quick solution. BSol CCG worked with different Primary Care services to analyse data and access better information to improve how services are configured. The biggest challenges were how to manage patient expectations and to inform good choices. This was based on the high volume of demand for the service, which had reach unprecedented levels.

Representatives from Solihealth, a GP Provider Alliance in Solihull, commented on their current experiences.

<u>Dr Sunaina Khanna – Clinical Director of GPS Healthcare:</u>
As a result of the COVID-19 pandemic and vaccination programme, GP practices within Solihull worked closely together to share good practice and to provide an efficient, resilient and sustainable service for local residents. They highlighted that even though demand had increased exponentially, they still received a lot of positive comments from patients.

They constantly reassessed how to increase face-to-face appointments, however there remained significant challenges. This included that waiting rooms were not able to cater for 30-40 people. As a result, it was important to have a plurality of offers to local residents, and to reassess this impact on

health inequalities. Alongside this, they had increased their workforce, however the bigger challenge was the retention of staff.

Another challenge was the increased demand for the service. This was from more people who had infections compared to 2020, the challenges of secondary care and the elective care backlog. They had also received an increase in mental health presentations, and attempted to support them in the community. It was also noted that COVID-19 booster jabs and the flu vaccine programme continued at pace.

Dr Dan Reid – Clinical Director of Solihull Rural Primary Care Network (PCN)
They explained how Solihull GPs had worked together under the Solihealth banner to address challenges within the system. It was emphasised that NHS England and Improvement required GPs to call and triage patients first, before face-to-face appointments.

Another point raised was that they had lost significant numbers of reception staff who had felt the pressure and behaviour of patients alongside the impact of the increased demand.

Dr Anand Chitnis – Clinical Director of North Solihull PCN
In addition to previous comments, they outlined that they had introduced pharmacists into practices to do medication reviews and care home reviews. This would free up time for GPs to undertake other tasks. Similarly, community nurses used digital technology to connect with GPs, paramedics were integrated into GPs and care coordinators provided lifestyle advice. This was part of a move to enable patients to receive rapid access support, and frees up demand for doctors and nurses to help patients.

It was also noted that there were benefits to this transformation, as patients would not be susceptible to waiting rooms viruses and the flexibility of virtual appointments.

Members and invited Councillors made comments and asked the following questions:

- Members thanked staff within primary care services for their support during the COVID-19 pandemic, and the work to resolve the current problems within the system.
- A Member asked whether all instances of abuse of staff by patients were investigated, and if there appeared any reasons for the abuse. The Chief Officer flagged that reasons for the frustrations were telephone wait times, challenges of the standard online offer and expectations of service. The Clinical Director of North Solihull PCN explained that queries which were emailed through would be noted and responded to, however it was often not the most appropriate method to contact the surgery. The Clinical Director of Solihull Rural PCN reaffirmed that email or digital access should not be used for urgent issues.
- A Member highlighted instances of people they had spoken to who had not been able to access face-to-face GP appointments or where

telephone consultations had inappropriate or poor outcomes. They queried whether the current system could be fixed to resolve the problems it faced at present. The Clinical Director of North Solihull PCN detailed that the pandemic had led to a number of problems within the system, and outlined that the pandemic had caused significant damage to many people within the Birmingham and Solihull region, which the NHS was not prepared for. A model had been put in place to try and mitigate the impact of the pandemic and prevent the health service from collapse, without this, the outcomes would have been significantly worse. However, demand had increased locally by 18% while the workforce had reduced, which meant some measures may not have been sufficient. It was suggested that to resolve this would require joined up working and clear messages from senior leaders to support staff within the system.

- Following this, the Member noted that certain patients would be unable to take phone calls during their work time. The Clinical Director of North Solihull PCN explained that they would attempt to have a conversation with the patient to work around their requirements, while conversely encourage the move to online support. It was confirmed that this would be discussed at a future Solihealth meeting. Similarly, the Clinical Director of Solihull Rural PCN confirmed that they would adapt their service to people's needs. The clinical director also stated that clinicians would prioritise their patients based on clinical need, it was therefore not always possible to provide a confirmed appointment time.
- Another Member commented that the terrible abuse faced by staff was a symptom of a problem within a system that was respected. There was a sense of crisis within the system and the message of change had not permeated the public consciousness. It was recognised that the pre-COVID-19 primary care services would not operate in the same way in the future, and asked that NHS colleagues worked with the Scrutiny Committee to support with this shift. In response the Chief Officer for Primary Care and Integration agreed that there needed to be strong communication with the public about the new operating model. Information on the steps taken would be shared with the Committee in the future.
- Councillor Richard Long (Solihull Council) stated the importance of communication, queried why there had not been improvements in the phone systems and asked if it was possible to have more specific time spaces for phone appointments. The Clinical Director of GPS Healthcare suggested that there were limited numbers of staff available to manage the phone lines, and these staff would need to be trained. A number of different models had been trialled to respond to these challenge and to support those who need it the most as quickly as possible. The Clinical Director of Solihull Rural PCN explained that the average call wait time had been reduced from 26 minutes to 9 minutes, even though call volume had increased 55%. GPs would identify which patients would require face-to-face appointments, however they would still need to receive a phone call first, which would slow the process down. The Clinical Director of North Solihull PCN also added that it was also a

safety issue that only patients which required face-to-face appointments would come to the surgery. They had drastically increased technological capacity over the previous 18 months, however it was still not possible at this point to provide the suggested on demand service.

- A Member explained that in their experience people often did not have the flexibility or time to wait for a call to be answered, and asked if there was an analysis of how often people made repeat calls or abandoned calls. The Clinical Director of GPS Healthcare reiterated that the biggest challenge remained the volume of patients that wanted to access the service. However, they continued to monitor the call data to provide the best service. The Chief Officer for Primary Care and Integration summarised that the comments on communication had been noted, and that there was significant demand on the service. They would work at a system level to share improvement and experience as well as how to introduce better ways of working. It would not be possible to introduce rapid change while the pressure remained, however there was significant steps to make the necessary improvements.
- A Member highlighted the importance of face-to-face appointments, especially for older people who may not be able to access virtual appointments. They questioned what the steps forward would be to improve the issues which had been highlighted. The Clinical Director for Solihull Rural PCN responded that the Solihull Rural PCN had significant amounts of over 80 year olds, and they were adaptive to the different needs of the population. This was seen as a health inequality if a resident did not have digital access, and therefore Solihealth had piloted a digital access programme for isolated elderly people to improve connectivity.
- Another Member agreed with previous comments that they should be honest that services would not immediately return to pre-COVID-19 levels. They then asked if the total triage requirement had led to the increased demand on the service, and if practices were locked into specific telephone contracts which they cannot switch from because of financial implications. The Chief Officer for Primary Care and Integration responded that the total triage model may take more time to conduct, however it was about how to balance safety across the whole patient list. BSol CCG had also supported GPs when they purchased telephone systems, but would check if it was a wider issue. The Member then queried whether there was a significant issue which prevented practices from dealing with the volume of calls. The Chief Officer explained it was likely a result of the volume of calls, while they had a modest sum to manage the service. As a result, there could not be significant staff increases, and this was problem was exacerbated by staff who had left the service because of the abuse they received.
- The Member queried if the salaries offered for the reception staff were a factor in recruitment difficulties, and stated additional resources were needed to ensure GPs could continue to function for patients. The North Solihull PCN agreed that additional resources were required and grateful for any support with this. It was reaffirmed that they continued to manage the COVID-19 pandemic, and that it was risky to give the public an

expectation that there would be a return to normality as the pandemic was not over. Also, they explained that the plurality of service had aided some people.

- A Member queried whether the increased demand was a result of more calls for standard issues or were there issues which had grown during the pandemic, such as mental health. They also asked about the communication of the new operating model as well as the use of the NHS 111 service. The Chief Officer for Primary Care and Integration confirmed that they would work with Councillors to improve the local communication of the operating model. The NHS 111 service remained available however it had also received a significant increase in demand during the pandemic. There was a local effort to encourage residents to make the right choices, such as to visit a pharmacist in some instances. Residents were encouraged to take the COVID-19 jab and the flu jab if invited.

RESOLVED

The Committee made the following **RECOMMENDATIONS**:

- That the current status of the system and its concerns and problems are well understood and accepted by BSol CCG.
- That there would be a move to an operating model which would improve experiences for patients and staff within the service.
- To receive a plan of how BSol CCG intend to deliver improved outcomes in primary care and better support all staff in the health services.
- To receive a copy of the guidance about the total triage model.

6. BIRMINGHAM AND SOLIHULL ICS FINANCIAL PLANNING 2021/22 UPDATE

The Chief Finance Officer, BSol CCG, introduced the item and highlighted the following points:

- It was expected that the Committee would be able to receive plans and guidance in relation to the allocation for the second half of the year. This was yet to be confirmed.
- The current position against the plan for the first half of the financial year was that there was a small surplus as month five across the system and expect to be in a break even position at month six. This highlighted that it was not finance which constrained the level of clinical services, instead there were a number of other constraints.
- They predicted that for the second half of the financial year, the financial framework was likely to remain similar to the first half. Allocations would be broadly similar, which would ensure that there would be additional funds to support the COVID-19 pandemic services, and to support recovery of services.
- There was an expectation that efficiency savings would be required in the future, which had been suspended during the COVID-19 pandemic. This was likely to be between 2-2.5%.

- Additional funding was anticipated to support the elective recovery fund as well as for the hospital discharge programme. A targeted investment fund had been announced to support systems significantly impacted by the COVID-19 pandemic. It was likely that University Hospitals Birmingham (UHB) would receive a share of this money.
- Even though a financial allocation had not been determined for the second half of the financial year, it was expected that they would be able to deliver a financially balanced position in the Birmingham and Solihull region. Finance was likely to provide more of a challenge in 2022-23. The funds from the health and social care levy would be seen as a way to make funding more sustainable.

Members made the following comments and questions:

- A Member noted their concern that the allocations for the second half of the financial year had not been confirmed. They sought clarification on whether the funding envelope would remain the same or reduced by 2%, as outlined in the PowerPoint slides. The Chief Financial Officer explained that the funding envelope was likely to be the same as the first half of the year, however the public sector pay award would be included in this settlement, which would require efficiency savings and clawback of additional COVID-19 funds.
- Another Member sought information on which areas would subject to efficiency savings. The Chief Financial Officer confirmed that the efficiency savings were unlikely to come from frontline services. They were likely to come from back office opportunities such as how telephony were organised. The benefits of the Integrated Care System (ICS) were likely to filter through, such as consolidation of procurement teams at acute hospitals.
- A Member asked for clarification about the underspend on Primary Care prescribing and CCG vacancies. The Chief Financial Officer clarified that they were in an unstable position to predict the continuing healthcare packages and primary care prescriptions. They had underestimated the demand for continuing healthcare packages, while overestimated the growth for primary care prescriptions and the increase in cost of drugs. A number of vacancies had also been held while the CCG moved to an ICS.

RESOLVED

Members noted the contents of the presentation and asked that comments raised were considered in future plans

7. UPDATE ON POST-COVID SYNDROME ('LONG COVID') REHABILITATION

The briefing note in the agenda reports pack was presented for information.

The Chair invited the Founder of Long Covid Support, Ms Claire Hastie, to share her experiences of COVID-19:

- In May 2020, Ms Hastie started a Facebook group for people who were struggling to recover from COVID-19 to share information and support. It

had around 45,000 members across 100 countries. This led to the creation of Long Covid Support, an organisation focused on peer support, advocacy, campaigning and research involvement. The organisation was represented on the NHSEI Long Covid Taskforce and the ministerial Long Covid Roundtable.

- They had an ongoing survey to gather insights into patient experiences of Long COVID services. Their most recent analysis showed 73% of people who sought referrals were able to secure these. It was outlined that there were over 200 reported symptoms of Long COVID, which made diagnosis difficult. Anyone could be affected, regardless of age or previous levels of health and fitness. Even people who were asymptomatic during the initial illness may develop Long COVID. Higher numbers of people of working age were affected.
- There was a substantial difference between the numbers assumed by NHSEI when they planned services and demand. There was also a number of serious illnesses associated with Long COVID.
- It was vital to prevent more cases. To assist with this, Ms Hastie called for additional symptoms to be added to the COVID-19 symptom list. Also, that siblings or close relatives of positive cases should isolate, and that children should be encouraged to wear masks in schools. Members were asked to support these measures and to follow the example of Cumbria County Council in calling for the reintroduction of protections.

Members made comments and asked the following questions:

- A Member asked if Long COVID would still impact people who had already been vaccinated. Ms Hastie confirmed that people who had been vaccinated could get Long COVID.
- A Member commented that there was a false sense of security about COVID-19, and the impact of Long COVID reaffirmed the importance to be vaccinated and to be tested regularly. Ms Hastie explained that it was important to test regularly, and to isolate when requested. It was highlighted that approximately 1 in 7 children who test positive for COVID-19 have Long COVID.

8. JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE - TERMS OF REFERENCE

The Joint Health Overview and Scrutiny Committee Terms of Reference were presented for approval.

RESOLVED
The amendments to the Terms of Reference were approved.

9. WORK PROGRAMME

The Work Programme for the Committee was presented for information.

A Member requested that an item would be included to outline the work to date on the creation of the ICS.

Members commented that it was a disappointment that Healthwatch Birmingham and Solihull were unable to attend the meeting to discuss primary care.

Members also requested that when Solihull Council hosted a Committee meeting that it would start at 5pm to assist with travel arrangements.

RESOLVED
The Committee approved the Work Programme.

The meeting finished at 8.25 pm

BIRMINGHAM/SOLIHULL JHOSC

2ND DECEMBER 2021

MID YEAR REPORT ON THE STAFF ENHANCED WELLBEING OFFER

PRESENTED TO BIRMINGHAM AND SOLIHULL PEOPLE BOARD ON 16 NOVEMBER 2021

Presented by: Lisa Stalley–Green, Chief Nurse UHB, Vice Chair People Board

1.0 Purpose

The purpose of this document is to provide

1. an overview of what the programme has delivered to date
2. agreed actions following the recent Health and Wellbeing Stakeholder Workshop
3. proposals for the future the ICS employee wellbeing offer

2.0 Background

The Birmingham and Solihull ICS is one of 14 pilot sites chosen by NHSE/I to develop and implement a Staff Enhanced Wellbeing Offer. In response to the invitation to bid for funding, BSol was awarded funding of £2 million in December 2020 to support the roll out of a series of initatives it determined would be beneficial for the BSol workforce building on existing good practice within the system. In addition £380,000 was awarded to establish a Staff Mental Health Hub (SMHH). A second round of funding awarded the SMHH an additional £1 million to continue its work. Funding for both programmes is due to end in March 2022.

It is to be noted that BSol were prioritised for both initiatives in recognition of the disproportionate impact of covid across the ICS population and workforce and very specifically on the impact of covid on the mental health of staff working in critical care services.

Both programmes of work have been led by a Strategic Leadership Group chaired by the SRO for the workstream, Lisa Stalley Green Executive Chief Nurse UHB and reporting into the People Board initially meeting monthly in order to get the programme and its governance established. This Group has recently revised its terms of reference to be more of an Oversight Group ensuring delivery and evaluation of the agreed prioirities and now meets quarterly.

A Health and Wellbeing Operational Group sits under the Strategic Group and is charged with leading the roll out of agreed initiatives across the Enhanced Offer and providing on the ground feedback on impact, staff feedback and new requirements.

A further Operational Group supports the Mental Health Hub provision in consultation with the CCG through which the funding is now routed.

3.0 Programme Delivery

3.1 Staff Enhanced Wellbeing Offer

The primary aim of the programme is to

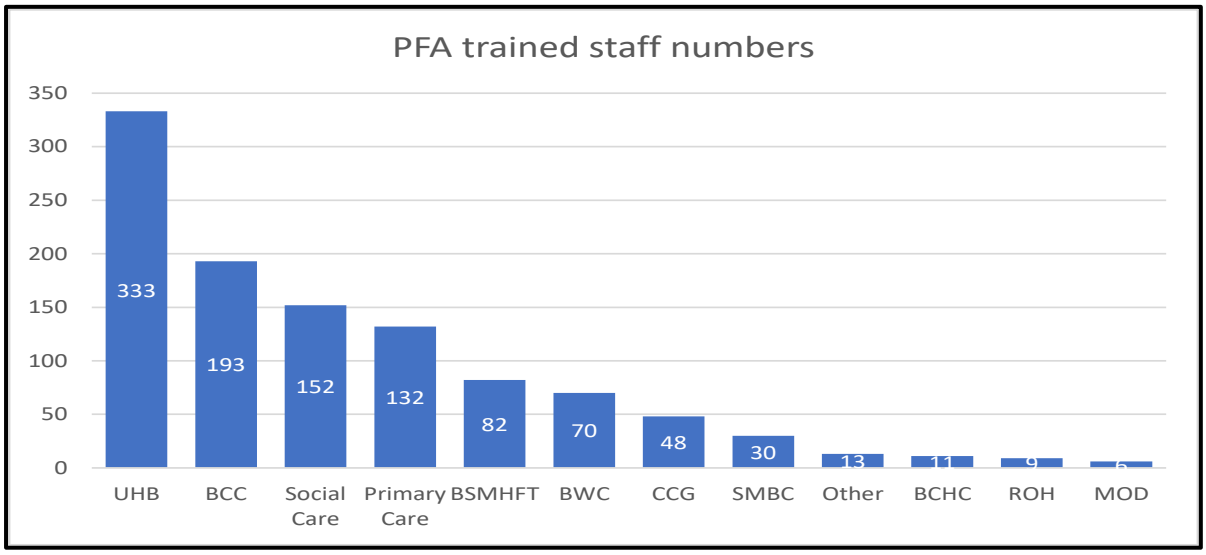
"Deliver an integrated occupational health and wellbeing offer across the whole of its health and care workforce system which provides staff with priority access to the services they require to enable them to be happy and health at work.

The initiatives outlined in the following sections have been implemented system wide, incorporating not just the NHS Trusts but also primary care and social care across the two local authorities, and as such have achieved a key aim of making aspects of wellbeing provision consistent across the system.

The following demonstrates the progress to date by initiatives:

Staff Offer 1a - Psychological First Aid training

This has probably been the most successful of the initiatives in terms of take up and acceptance by staff. Staff have been trained in psychological first aid in all health and care environments, and work is continuing to ensure a representational spread across stakeholders based on employee head count. The graph below details the spread of PFA trained staff up until the end of September. The data for October is still being cleansed. Presently data shows that approximately 1100 employees are PFA trained with this likely to rise to approximately 1300 when accounting for the October numbers. There are still eight sessions of the training to be delivered.



Staff Offer 1b - Supervision of Psychological First Aid trained staff

Those staff who are PFA trained required a reporting mechanism to ensure their psychological safety. This has been achieved through In-house trained supervisors, as well as an agreement with the Staff Mental Health Hub to Provide Reflective Practice Groups

Staff Offer 2 - Staff Wellbeing Ambassadors (formerly Staff Safety and Wellbeing Officers)

This initiative is underway with a job responsibilities document drafted and which is aligned to the NHSE/I Wellbeing Champion role. An information collection exercise is being

undertaken with stakeholder organisations to determine current provision. Stakeholders may have individuals already in place with a different name but with similar responsibilities.

Staff Offer 3 - Enhanced Support for Managers
So far has been in the form of webinars that are both live broadcasts and pre-recorded delivered by NHS Elect. Two live broadcasts per month and pre-recorded webinars that can be accessed at any time are being offered.
There have been five live broadcasts to date with 150 employees booked on to the sessions. Presently figures of those who have accessed the pre-recorded webinars are not available, but these are being collated by the training organisation.

Staff Offer 4 - Physical Health and Wellbeing Hubs
Funding has been given directly to eight stakeholder organisations via a proposal system to realise this initiative, with one proposal currently outstanding. As a result of the funding a number of stakeholders were able to establish employee wellbeing physical spaces, that would not have been possible without the funding. Other stakeholders have been able to develop or maintain an existing service.
At present we are collecting information from stakeholders on the impact that these physical spaces have had.

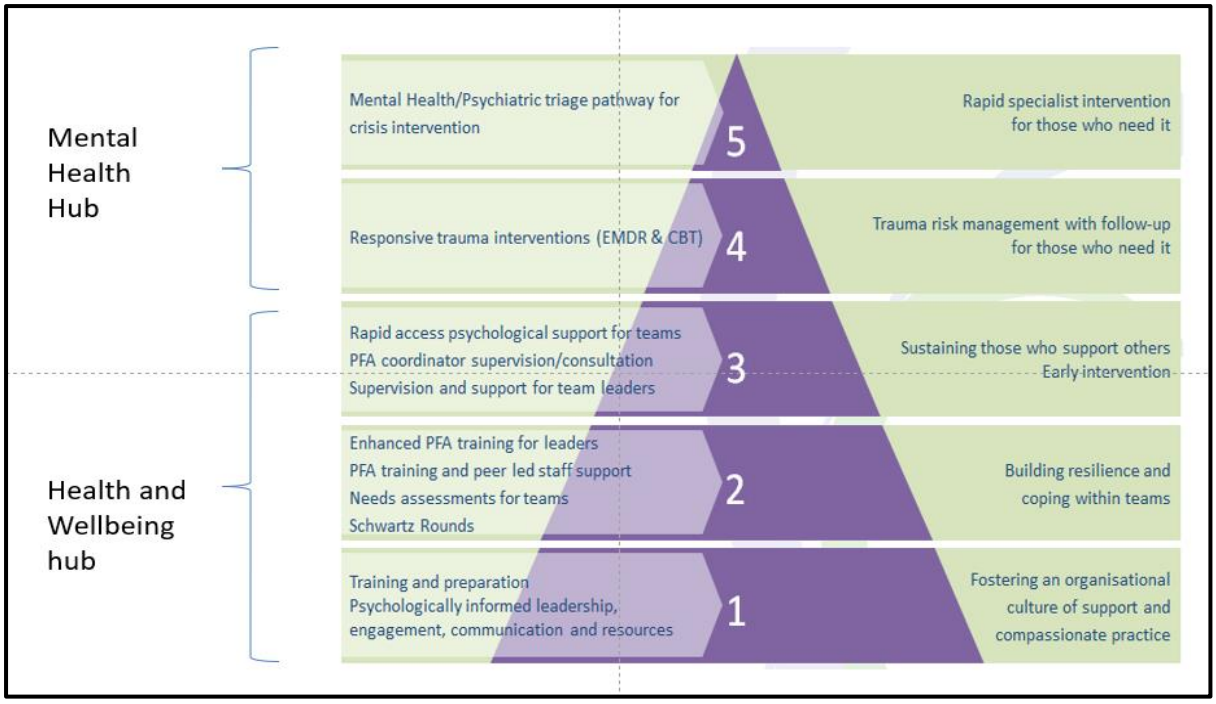
Staff Offer 5 - Population Specific Health Clinics
This initiative has yet to be implemented as it was determined that due to the changing Covid situation, data on employee health priorities may not be accurate. A brief survey was sent to employees across the system to gather this information and there were 180 respondents. The three primary priorities where staff would benefit from an intervention were 1) musculoskeletal 2) counselling 3) physical activity / Inactivity. Discussions are taking place with stakeholders to determine how the priorities can best be realised in tandem with the work to review occupational health services.

Staff Offer 6 - Enhanced Use of Digital Resources
On September 1st 2021 the BSOL ICS website went live, and the website has a section for the health and wellbeing initiatives. The website is important as it brings together information from the individual stakeholders and is a useful resource to advertise and promote system wide initiatives. Presently the pages are information giving but are being developed to be more interactive and product focused including details of training available, community pages, and toolkits etc.

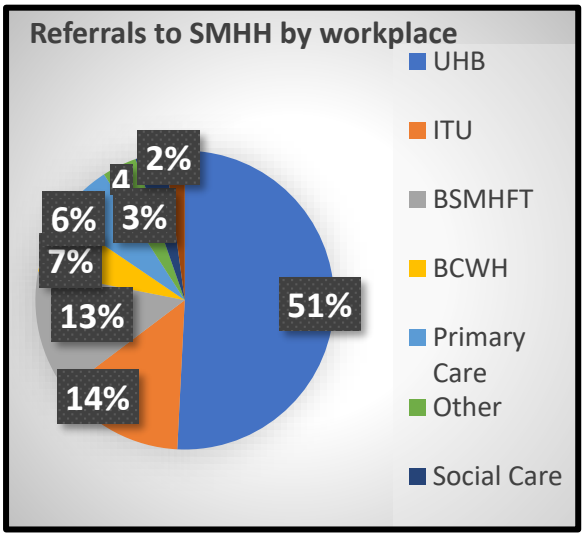
Staff Offer 7 - Tailored support to specific areas of the workforce
Although this initiative has not been fully realised, advanced discussions are ongoing with internal and external providers. This support includes a menopause app and toolkit, a post covid support package, as well as training and resources to support those with addiction issues.

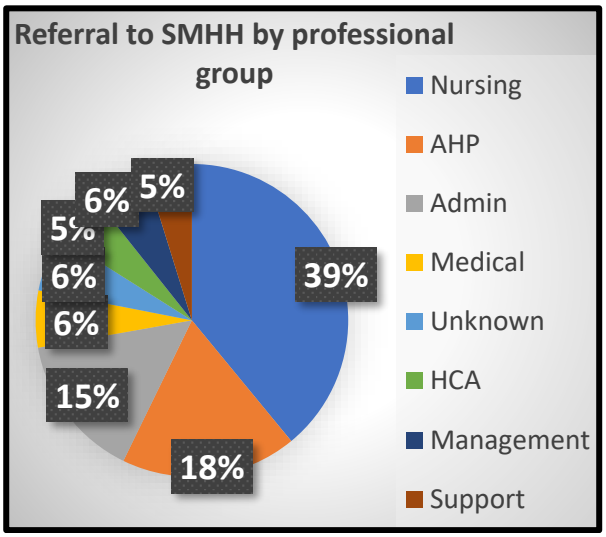
3.2 Staff Mental Health Hub

Staff Mental Health Hub
The Staff Mental Health Hub was established in January 2021 to provide a service to those employees with more complex psychological needs.



Employees can self-refer or with their permission, be referred by a colleague. The Staff Mental Health Hub is seeing 15 – 30 referrals per month from with all stakeholder organisations represented. The graphs below display data relating to referrals.





The nature of cases include mood and anxiety reactive to covid related stressors, trauma responses often complicated by life events, long covid, pre-existing or concurrent mental health difficulties aggravated by working through covid. Also some non-covid related cases have been seen. Moving forward, the Staff Mental Health Hub intends to:

- More pro-active with social care – currently mapping the sector
- Focus on qualitative and quantitative outcomes evaluation – assistant psychologists
- Consider future with or without continued funding
- Capture learning for future provision at both system and some organisational levels
- Continue to respond to individual referrals as to date
- Continue to support training across system

3.3 Staff Vaccination Programme

Additional to the above programmes of work, the ICS People Board played a key role in the early staff vaccination programme supporting the main vaccination hub to identify the social care and private, independent and voluntary sector staff eligible for vaccination. In the first instance this was prioritised to frontline staff so necessitated a significant engagement exercise to identify the eligible staff across these sectors. The work led by the People Board SRO for Health and Wellbeing identified 57,000 staff outside of the NHS organisations across more than 1000 organisations, and worked with their managers / organisations to ensure quick and easy access to vaccination provision. The work undertaken has been invaluable in terms of understanding the wider ICS workforce and its many provider organisations and in establishing key stakeholders in support of the work of the People Board. Subsequent work is under discussion around vaccine compliance resultant from the recent and forthcoming government legislation working with the People Board SRO for Workforce, Cathi Shovlin. The work will focus on the impact on workforce availability, the level of risk presented and the impact and overall management as an ICS.

Trust	1st	2nd	Cumulative	Number of staff	% one dose	% both doses
Birmingham and Solihull Mental Health NHS Foundation Trust	5,003	4,728	9,731	5,954	84.0%	79.4%
Birmingham Community Healthcare NHS Foundation Trust	5,104	4,838	9,942	5,976	85.4%	81.0%
University Hospitals Birmingham NHS Foundation Trust	16,215	15,267	31,482	18,665	86.9%	81.8%
Birmingham Women's and Children's NHS Foundation Trust	5,185	4,958	10,143	5,863	88.4%	84.6%
Royal Orthopaedic Hospital NHS Foundation Trust	1,344	1,284	2,628	1,490	90.2%	86.2%

4.0 Review of Future Provision

The current programmes of work are now well established and an evaluation is being commissioned to review the impact of the interventions on staff and how widely the offers have been taken up across different organisations.

It was felt this would be a good time to review future provision both in the context of the continuing impact of covid on staff health and wellbeing and also in preparation for the ICS becoming a statutory organisation and the anticipated changes to the way it will work as a system going forward.

In order to inform a proposed way forward.

The Health and Wellbeing Leadership Steering Group facilitated a strategic Workshop on 21st October 2021 , with approximately 40 colleagues representing all stakeholders, in attendance. Topics discussed included the staff wellbeing needs in the long term, staff engagement and the future of Occupational Health Provision. A summary of the discussions follows.

4.1 Staff wellbeing needs
Attendees brought forward a number of subjects which are included in the table below. These have been linked to the recommendations for health and wellbeing detailed in the NHS People Plan for your information.

THEMES DISCUSSED DURING WORKSHOP	WELLBEING PEOPLE PLAN RECOMMENDATIONS
Safety of workforce x 3	Support staff to use other modes of transport and identify a cycle-to-work lead.
Staff well clinics x 2 Weight loss support Access to substance misuse resources Menopause support x 3	
Staff well clinics x 2 Weight loss support	Ensure that workplaces offer opportunities to be physically active and that staff are able to access physical activity throughout their working day.
Work life balance – home working	Ensure people working from home can do safely and have support to do so, including having the equipment they need.
Breaks	Ensure people have sufficient rests and breaks from work and encourage them to take their annual leave allowance in a managed way.
Work culture Healthy teams / healthy relationships	Prevent and tackle bullying, harassment and abuse against staff, and a create a culture of civility and respect. Provide a toolkit on civility and respect for all employers.
Physiotherapy	Identify and proactively support staff when they go off sick and support their return to work.
Wellbeing becomes business as usual Recognition of employee efforts Doing nice things for employees	Make sure line managers and teams actively encourage wellbeing to decrease work-related stress and burnout. Every member of NHS staff should have a health and wellbeing conversation. All new starters should have a health and wellbeing induction.
Safe spaces	Ensure staff have safe rest spaces to manage and process the physical and psychological demands of the work.

PEOPLE PLAN RECOMMENDATIONS – NOT MENTIONED DURING THE WORKSHOP

WELLBEING PEOPLE PLAN RECOMMENDATIONS	STATUS
Complete risk assessments for vulnerable staff, including BAME colleagues and anyone who needs additional support, and take action where needed.	Actioned by stakeholders in NHS Trusts
Appoint a wellbeing guardian.	Actioned by stakeholders, in NHS Trusts
Continue to give staff free car parking at their place of work.	Not actioned by stakeholders, in NHS Trusts
Ensure that all staff have access to psychological support.	Actioned by stakeholders in NHS Trusts with some provision in wider health care

5.0 Proposed BSol ICS offer

Whilst many organisations had a level of provision prior to covid, the last 18 months have seen a seismic shift in the recognition of the need to focus on staff health and wellbeing across a range of required interventions from early psychological assessment and care through to menopause support, access to addiction help and time and space to rest, reflect and recover.

BSOL has benefited from the funding it has received and which has enabled wide access and some levelling up of workforce support. As a system we now aspire to continue on this critical work and become a **System of Excellence** for delivering a staff wellbeing offer. To realise this aspiration 4 key elements are proposed:

Proposal 1: Understanding the workforce
Proposal 2: Staff engagement and the staff voice
Proposal 3: Future Occupational Health Provision
Proposal 4: A wellbeing strategy

5.1 Proposal 1 - Understanding the Workforce

The BSOL ICS footprint encompasses 80,000 employees and this number grows substantially when accounting for the wider health and care organisations. To be fully successful in implementing a wellbeing offer that is relevant and includes tailored components for specific groups of the workforce, a detailed understanding of the workforce is required. This understanding includes but is not limited to:

- demographical data – initiatives such as menopause resources and health clinics will be more relevant to certain employees
- primary reasons for sickness absence – initiatives that tackle reasons for absence such as musculoskeletal issues and psychological health will not only keep staff in work but will have a positive financial impact

This understanding also extends to recognising and appreciating the pressures that staff, both clinical and non-clinical have faced, but more important are facing is required. The wellbeing offer can also then be linked to other workstreams such as:

- **Staff Retention** - Health is a key reason for leaving in both Health and Social Care for staff aged 50-54 age category
    - Adult Social Care have 23% aged 55 and above,
    - NHS Providers have 18% of staff aged over 55 and 25% are over 45
    - Retirement accounts for 24.5% of leavers
    - Risk of retirement of staff increasing, due to the increased number of staff over 55 in clinical and non-clinical roles in both Health and Social Care
    - Increase in referrals to the Mental Health Hub for student who are transitioning into qualified roles

- Recommended action is to:
    - Engage with staff over 50 to understand their health, wellbeing and career needs and what would support them to stay in work.
    - To include mid-life career conversations to understand their aspirations and/or wants and needs and role fatigue to enable improvements to be made for future generations.

- **Restoration and recovery** - Workforce is the biggest risk to elective recovery and in addition to this winter pressures need to be managed effectively. There are significant pressures on the current workforce caused by
    - increasing numbers of vacancies across Nursing & Midwifery
    - leavers in the first year of employment now representing 24%
    - clinical support vacancies
    - a trend of rising turnovers across a number of providers.

- Whilst Sickness rates have stabilised in recent months there continues to be pressurised areas such as Emergency Department and Critical Care.

- **Equality, diversity and inclusion** – This key aspect of employee wellbeing has been incorporated into the current staff wellbeing offer. It is paramount that this work continues through analysis of all available data, but more importantly listening to and acting on feedback from the workforce.

It is proposed that the data required is routinely collected and collated.

5.2 Proposal 2 - Staff Engagement and the Staff Voice

Staff engagement in promoting and advising staff on the wellbeing initiatives is an essential component moving forward. The recent Leadership Steering Group strategy workshop discussed staff engagement and common methods of communication are presented in the table below.

However messages are communicated to engage staff, it is key to ensure consistency of the message throughout the year. This will lead to embedding a wellbeing culture across ICS. A potential way that this could be achieved would be the creation of the role of a dedicated wellbeing Communications Lead.

TECHNOLOGY	FACE TO FACE	PRINT
Yammer (Microsoft 365)	Verbal briefing packs	Regular updates
Text alerts	Staff Wellbeing Ambassadors	
Short films	Schwartz rounds	
Social media		
ICS website		
To consider: Timing of communications for different working patterns Seek out opportunities to introduce wellbeing into the working day How to embed wellbeing into working practice		

There are many existing ways in which staff views and opinions are collected including the NHS Staff Survey, NHSE/I Pulse Survey and local stakeholder staff questionnaires. Although useful they often provide a snapshot rather than a real time perspective. This shortcoming could be overcome through:

- Regular, scheduled listening events potentially utilising the skills of stakeholder Wellbeing Guardians or similar
- System wide implementation of the Staff Wellbeing Ambassador role (SWA). These individuals, embedded within teams, would provide ongoing rich data on the opinions of staff. Although most likely an unpaid role, to be truly effective, protected time would be required to fulfil these responsibilities.
- The use of technology via the ICS website (bsolpeople.nhs.uk) or commercially available feedback options (viewpointfeedback.com), where short surveys and employee communities can be incorporated

It is proposed that The People Board accept the points made above as a starting point for the development of a comprehensive staff engagement / staff voice strategy.

5.3 Proposal 3 - Future Occupational Health Provision

The 'Growing Occupational Health' was launched in 2021 for mature and collaborative OH Services to undertake service improvement projects across 4 systems nationally. The Midlands were one of 3 regions who did not benefit from this. Some funding has been ring-fenced for the Midlands to undertake work reviewing OH services locally in two phases over 3 months; the **design** phase to review key players and identify clear purpose and focus of the work; and the **discovery** phase which will review how we can transform OH services, review learning opportunities, gain insights from managers and service users, review service provisions, baseline service provision, use of technology and policy and procedure. Two OH Physicians have been identified, one from Birmingham and Black County ICS and the other from East Midlands. Leadership support and oversight along with service engagement support have been requested from a Leader within the BSOL ICS with local system and trust experience. An experienced leader from BWC has offered support for a 3 months period, 1 day per week to progress this work on behalf of the BSOL ICS.

It is proposed that The People Board commission Bethan Downing from BWC to undertake this work on behalf of the BSOL ICS.

5.4 Proposal 4 - A Wellbeing Strategy

An aim of the original pilot proposal on which NHSE/I funding was based read:

"*This pilot will enable this shared ambition be translated from a strategy into the delivery of a health and wellbeing offer for the staff across the BSol region.*"

It is proposed that this is the time to formulate a system wide wellbeing strategy that all stakeholders can sign up to. The pandemic has placed a greater emphasis on the health and wellbeing of staff, not just within the NHS but also within the wider health and care community. Colleagues have endured many hardships in the last 20 months and a ICS led wellbeing strategy would not only maintain the focus of “looking after our people” and protect the right to a happy and healthy workplace, it is the right thing to do.
The wellbeing strategy could be built around:

- Recommendations from the NHS People Plan, which are relevant not just to the five NHS Trusts but also to other ICS stakeholders
- Three specific overarching themes - physical wellbeing, psychological wellbeing and workplace culture
- A set of commitments within each theme that provides a baseline standard for stakeholders to implement. These commitments will enable staff to know exactly what the wellbeing offer is but will also underline the importance placed on wellbeing by employers.
- Commitments that each stakeholder signs up to with examples being
    - all new starters should receive a wellbeing conversation within four weeks of being in post
    - staff are entitled to free quarterly health check ups
    - a co-ordinated referral pathway for issues relating to psychological health that incorporates all of the provision across the ICS stakeholders
    - access to safe spaces

It is proposed that an ICS wellbeing strategy be drafted for consideration by stakeholders.

6.0 Future Role of the ICS
The centralised funding awarded to enhance the staff wellbeing offer across BSOL has undoubtedly had success in enabling wellbeing initiatives to be implemented at a system level. The delivery of many of the initiatives would not have been possible or would not have reached as many colleagues without this centralised approach and inequalities in provision have been lessened. There is no certainty of future national funding for the enhanced Health and Wellbeing offer and therefore consideration will need to be given to what level of centralised provision the ICS wishes to continue with and therefore resource.

The options to consider are therefore:
1) The ICS continues to play a role in both centrally commissioning and providing an agreed level of enhanced health and wellbeing

2) The ICS sets the core standard and expectation for a heath and wellbeing offer at either the ICS or at Provider Collaborative Level and as such provides support for local provision and assurance for delivery to the ICB Board.

7.0 Recommendations
The People Board are asked to review discuss and support the five proposals which will then be taken forward through the existing governance route described in section 2.

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H2 Planning and the development of a Multi-Year Recovery Plan
Joint Health and Social Care Overview and Scrutiny Committee
2 December 2021

Paul Athey, Chief Finance Officer

Purpose

- To provide the committee with an update on the latest position for the H2 (Q3-Q4 2021/22) Plan and the approach to the development of the ICS Multi-Year System Recovery Plan

- To provide the committee with oversight on the risks and mitigating actions

Context

- A shadow ICS is in place for BSol to support collaboration and integration across health and care
- We are working together as a system to respond to the challenges as we recover from COVID
- Planning this year is in two parts to enable systems to respond to the challenges and needs of COVID
  - H1 covers Q1 and Q2 – submitted in June
  - H2 covering Q3 and Q4 – submitted in November
- Nationally, COVID has had an impact on waiting times. As a result, all ICSs have been asked to develop an system wide recovery plan to get back on track. In BSol, we are also planning for beyond 2021/22 with a multi-year recovery plan
- National funding has been available through the Targeted Investment Fund and Winter Monies to help systems manage pressures and recover

H2 summary of national priorities

WORKFORCE

Staffing to **support elective recovery**

Move towards **system workforce planning** in readiness for Integrated Care Boards

RESTORING AND INCREASING ACCESS TO PRIMARY CARE SERVICES

Prioritise local investment and support for GPs including recruitment and retention

Provide access to pre-pandemic appointment levels, including face to face care

ELECTIVE RECOVERY

Eliminate **104 week waits**

Reduce or hold number of patients waiting over 52 weeks

Stabilise waiting lists around Sept 2021 levels

Optimise Advice and Guidance and grow remote outpatients

Implement **patient initiated follow-up** for 5 major specialties

Accelerate rapid diagnostic centres to achieve 50% conversion

Return 62 day waits to Feb 2020 levels

Ensure **75% of patients will have cancer ruled out or diagnosed within 28 days of referral**

TRANSFORM COMMUNITY, URGENT AND EMERGENCY CARE AND IMPROVE DISCHARGE

Increase levels of discharge and reduce length of stay for over 21 days

Continue providing **2 hour community response teams** 8am-8pm, 7 days per week

Reduce number and duration **ambulance handover delays**

Eliminate 12 hour waits in ED

H2 key risks and mitigations

The key risk is on addressing elective waiting times – specifically:

- Stabilising waiting lists at the September 2021 level
- Reducing or holding the numbers of people waiting 52 weeks
- Returning people waiting 62 days or more to February 2020 levels
- Ensuring sufficient workforce availability to support our elective recovery (and reduce waiting lists)
- Putting in place patient initiated follow up in at least 5 outpatient specialties

Mitigations include:

- Maximising our theatre capacity and allocation across the system
- Maintaining a 'green' site focused on critical care, supported by ITU expansion and ward expansion at UHB in Q3
- Reviewing patient waiting lists and prioritising these based on harm reviews and level of need
- International recruitment for critical care and theatre nurses plus bank staff and locum support for specialties
- Securing independent sector capacity nationally and locally
- Delivering 'Super Saturdays' to deliver high volumes of activity to reduce the waiting list
- Reviewing how patient initiated follow-up is working in the four areas where it is already live (dermatology, musculo-skeletal, endocrinology, gastroenterology). Work is in progress for cancer services

Elective recovery challenges

Factors that could affect our elective recovery are:

- Rising COVID rates - this will create pressures in ITU and high dependency units and result in redeployment of staff
- Staff sickness
- Winter pressures impacting on flow and bed availability
- Managing widening inequalities linked to increased demand for care and widening health inequalities
- Construction delays which impact upon capacity expansion

These factors are being managed as far as possible with mitigations in place.

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H2 Financial Planning – 2021/22

H2 Financial Planning

- The H2 (Half 2 – October 21 to March 22) allocation for Birmingham and Solihull was £1.22bn, £23.3m higher than the equivalent allocation for H1.
- BSol ICS is able to access a range of other funding sources outside of core allocations:
  - Hospital Discharge Programme
  - Primary Care Winter Access Funding
  - Targeted Investment Funding
  - Service Development Funding (SDF)
  - Elective Recovery Funding (including "underwriting scheme")
  - Centrally funded COVID schemes (e.g. vaccination programme)
- **All BSol NHS organisations, and the system in total, are planning for a breakeven position for 21/22.**

H2 System Allocation Changes	£000
Core allocation growth	£11,688
Growth - other allocations	£3,216
Funding for H1 pay award backpay	£15,965
System efficiency target	(£10,455)
Covid funding clawback	(£4,840)
Provider income loss funding clawback	(£1,317)
System Capacity Funding	£9,018
TOTAL	**£23,275**

Additional funding for development, recovery and winter pressures

Hospital Discharge Programme

- £11.6m, funding various schemes introduced as part of the COVID response and excess costs of existing discharge pathways. This funding will cease on 31 March 2022.

Primary Care Winter Access Funding

- Potential £5.9m (subject to NHSEI approval), funding primary care surge capacity, oximetry at home and at-scale models for expanded GP access.

Targeted Investment Fund

- £13.4m revenue and £16.8m capital supporting various elective recovery schemes:
  - Capacity expansion programme at Queen Elizabeth Hospital (QEH), Birmingham Heartlands Hospital (BHH) and Good Hope Hospital (GHH)
  - Enhanced perioperative care units at QEH and Solihull Hospital
  - Respiratory support units at QEH, BHH and GHH
  - Digital transformation at UHB, ROH and across primary care

Elective Recovery Funding

- BSol does not expect to meet the threshold for access to Elective Recovery Funding , however conversations are ongoing regarding the potential underwriting of the marginal cost of planned activity increases in H2.

H2 system efficiency schemes

- £10.4m of targeted efficiency required, in addition to the efficiency requirement implicit within provider inflation funding
- £3.3m of commissioner-led efficiency schemes identified to date:
  - £1.0m - Continuing Healthcare – Reestablishment of initial assessments within 4-week funded window
  - £0.8m – Prescribing schemes – Cost effectiveness, waste reduction schemes and medication reviews, primarily through the Primary Care universal offer
  - £0.6m – Functional Mental Health packages – Focused review of high cost packages
  - £0.5m – Enhanced Assessment Beds - Consolidation of contracts for non-NHS enhanced assessment beds to improve utilisation as part of the interim stages of the Early Intervention Pathway 2 bed strategy
  - £0.4m (non-rec) – Vacancies on CCG running costs
- Provider schemes still being finalised – will update at JHOSC meeting

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Multi-Year Recovery Plan

Multi-year recovery plan

- **Context** - given COVID, it will take time to recover and address our performance challenges
- **Aims -** The multi-year recovery plan will bring the system together to plan for the next 4 years - transformation and sustainability is key
- **Locally driven** - The plan is locally driven (i.e. this is not a national requirement). It gives BSol the opportunity to bring together our collective assets so we can improve services and outcomes
- **Content -** the plan will include:
  - A detailed case for the first 2 years will cover waiting times, diagnostics, ambulance handovers and inequalities
  - How we will address and reduce waiting times for patients - through increased capacity and expansion to our workforce either through planned or emergency treatment
  - How we streamline access to elective and urgent and emergency care over the next 4 years for our patients
  - The case for further system investment to fund the additional capacity required
  - Timelines for when we expect waiting times to be in line with national requirements
  - How we mainstream best practice and innovation
  - Proposals for permanent service changes or site reconfigurations to enable timely access to care

Next steps

- 26/11/21 - Multi-year recovery plan to submitted to NHSEI
- December – Discussions between system partners and NHSEI to refine plans
- December-March
  - Implementation and delivery of H2 priorities
  - 2022/23 planning
  - Reviewing proposed permanent service changes

Questions

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